**WORKER'S DISABILITY COMPENSATION ACT OF 1969 (EXCERPT)**
**Act 317 of 1969**

## 418.315 Furnishing medical care for injury arising out of and in course of employment; optometric service; chiropractic service; attendant or nursing care; selection of physician by employee; objection; order; other services and appliances; proration of attorney fees; fees and other charges subject to rules; advisory committee; excessive fees or unjustified treatment, hospitalization, or visits; review of records and medical bills; "utilization review" defined; effect of accepting payment; submitting false or misleading information as misdemeanor; penalty; improper overutilization or inappropriate health care or health services; appeal; criteria or standards; certification; unusual health care or service.

Sec. 315. (1) The employer shall furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of this state as legal, when they are needed. However, an employer is not required to reimburse or cause to be reimbursed charges for an optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992 or for a chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009. An employer is not required to reimburse or cause to be reimbursed charges for services performed by a profession that was not licensed or registered by the laws of this state on or before January 1, 1998, but that becomes licensed, registered, or otherwise recognized by the laws of this state after January 1, 1998. Attendant or nursing care shall not be ordered in excess of 56 hours per week if the care is to be provided by the employee's spouse, brother, sister, child, parent, or any combination of these persons. After 10 days from the inception of medical care as provided in this section, the employee may treat with a physician of his or her own choice by giving to the employer the name of the physician and his or her intention to treat with the physician. The employer or the employer's carrier may file a petition objecting to the named physician selected by the employee and setting forth reasons for the objection. If the employer or carrier can show cause why the employee should not continue treatment with the named physician of the employee's choice, after notice to all parties and a prompt hearing by a worker's compensation magistrate, the worker's compensation magistrate may order that the employee discontinue treatment with the named physician or pay for the treatment received from the physician from the date the order is mailed. The employer shall also supply to the injured employee dental service, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably possible, and relieve from the effects of the injury. If the employer fails, neglects, or refuses so to do, the employee shall be reimbursed for the reasonable expense paid by the employee, or payment may be made in behalf of the employee to persons to whom the unpaid expenses may be owing, by order of the worker's compensation magistrate. The worker's compensation magistrate may prorate attorney fees at the contingent fee rate paid by the employee.

(2) Except as otherwise provided in subsection (1), all fees and other charges for any treatment or attendance, service, devices, apparatus, or medicine under subsection (1), are subject to rules promulgated by the workers' compensation agency pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. The rules promulgated shall establish schedules of maximum charges for the treatment or attendance, service, devices, apparatus, or medicine, which schedule shall be annually revised. A health facility or health care provider shall be paid either its usual and customary charge for the treatment or attendance, service, devices, apparatus, or medicine, or the maximum charge established under the rules, whichever is less.

(3) The director of the workers' compensation agency shall provide for an advisory committee to aid and assist in establishing the schedules of maximum charges under subsection (2) for charges or fees that are payable under this section. The advisory committee shall be appointed by and serve at the pleasure of the director.

(4) If a carrier determines that a health facility or health care provider has made any excessive charges or required unjustified treatment, hospitalization, or visits, the health facility or health care provider shall not receive payment under this chapter from the carrier for the excessive fees or unjustified treatment, hospitalization, or visits, and is liable to return to the carrier the fees or charges already collected. The workers' compensation agency may review the records and medical bills of a health facility or health care provider determined by a carrier to not be in compliance with the schedule of charges or to be requiring unjustified treatment, hospitalization, or office visits.

(5) As used in this section, "utilization review" means the initial evaluation by a carrier of the appropriateness in terms of both the level and the quality of health care and health services provided an injured employee, based on medically accepted standards. A utilization review shall be accomplished by a carrier pursuant to a system established by the workers' compensation agency that identifies the utilization of health care and health services above the usual range of utilization for the health care and health services based on medically accepted standards and provides for acquiring necessary records, medical bills, and other information concerning the health care or health services.

(6) By accepting payment under this chapter, a health facility or health care provider shall be considered to have consented to submitting necessary records and other information concerning health care or health services provided for utilization review pursuant to this section. The health facilities and health care providers shall be considered to have agreed to comply with any decision of the workers' compensation agency pursuant to subsection (7). A health facility or health care provider that submits false or misleading records or other information to a carrier or the workers' compensation agency is guilty of a misdemeanor punishable by a fine of not more than $1,000.00 or by imprisonment for not more than 1 year, or both.

(7) If it is determined by a carrier that a health facility or health care provider improperly overutilized or otherwise rendered or ordered inappropriate health care or health services, or that the cost of the health care or health services was inappropriate, the health facility or health care provider may appeal to the workers' compensation agency regarding that determination pursuant to procedures provided for under the system of utilization review.

(8) The criteria or standards established for the utilization review shall be established by rules promulgated by the workers' compensation agency. A carrier that complies with the criteria or standards as determined by the workers' compensation agency shall be certified by the department.

(9) If a health facility or health care provider provides health care or a health service that is not usually associated with, is longer in duration in time than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health facility or health care provider may be required by the carrier to explain the necessity or indication for the reasons why in writing.

**History:** 1969, Act 317, Eff. Dec. 31, 1969;—Am. 1975, Act 93, Imd. Eff. May 27, 1975;—Am. 1981, Act 195, Eff. Mar. 31, 1982;—Am. 1985, Act 103, Imd. Eff. July 30, 1985;—Am. 1994, Act 271, Imd. Eff. July 11, 1994;—Am. 1995, Act 21, Imd. Eff. Apr. 12, 1995;—Am. 1998, Act 447, Imd. Eff. Dec. 30, 1998;—Am. 2009, Act 226, Imd. Eff. Jan. 5, 2010.

**Compiler's note:** For legislative intent as to severability, see Compiler's note to MCL 418.213.

For transfer of health care-related cost containment functions from the Bureau of Worker's Disability Compensation, Department of Labor, to the Office of Health and Medical Affairs, Department of Management and Budget, see E.R.O. No. 1982-2, compiled at MCL 18.24 of the Michigan Compiled Laws.

For transfer of duty to conduct hearings pursuant to MCL 418.315(7) to the Bureau of Workers' Disability Compensation, Department of Labor, see E.R.O. No. 1986-3, compiled at MCL 418.1 of the Michigan Compiled Laws.

For transfer of workers' compensation administrative rules functions to the Bureau of Workers' Disability Compensation, Department of Labor, see E.R.O. No. 1990-1, compiled at MCL 418.2 of the Michigan Compiled Laws.

**Transfer of powers:** See MCL 418.315 and 418.991.

**Popular name:** Act 317

**Popular name:** Heart and Lung Act

**Administrative rules:** R 418.10101 et seq. and R 418.10104 et seq. of the Michigan Administrative Code.